MEDICAL DIVISIONAL CLINICAL GOVERNANCE COMMITTEE

FEEDBACK REPORT

Directorate Name: Department of Critical Care **Presented at DCGSG on**: 30 May 2006

Clinical Risk Initiatives (including feedback from any incident reports)
Problems with CT down-time and access to regional centres continue. Fewer incident reports (particularly trigger incident reports) are being received. It is possible this reflects increased staff workload. The unit continues to struggle matching patient demand with resources. Cancellations of elective surgery continue, with one patient in breech of cancer targets.
Audit/Research
Another six internal audits (reaudits) were presented in February. The majority of these audits are not registered with the Audit Office because of the additional work involved to put the audit and its outputs in a standardised format. Copies of all completed audits are stored on the DCC Server Farm. An audit of the delay between admission and documented consultant involvement (based on NCEPOD standards) showed that only 56% of patients met the standard stop. Suprisingly, 17% of patients were admitted and discharged without any documentation of consultant involvement. In our unit, this is clearly a documentation failure, and changes have been made to correct this. On a national level, the new Critical Care Minimum Data Set has been implemented and is being recorded electronically. We are preparing for the roll-out of a new version of the ICNARC data set.
Information Initiatives
The new discharge summary is now in use. The ICE order and reporting system for laboratory results has been implemented. There remains confusion between the use of the ICE and the old APEX systems. Our data management group is continuing to refine and simplify the data

collection and reporting process within DCC.

Work has begun on developing a new approach to documentation during transfers since the link between monitors and CIS is now operative.

Patient/Public Involvement/Empowerment Initiatives

Summary of Follow-up clinic results and funding presented at multi-disciplinary meeting (100% support for clinic).
Number of patient diaries being increased based on feedback.

Human Resource Issues/Developments within the directorate

The DCC pharmacist post, the Follow-up nurse and new consultant appointments are delayed in the vacancy control process.

A new team structure for bedside nursing will be implemented once Health Care Support Workers are recruited and trained. The changes will decrease nursing costs without decreasing capacity or the quality of care.

The current staffing restrictions have led to a loss of educational and administrative time, as well as putting more stress on staff. There is a real risk that loss of educational and administrative time will hurt the department.

Permanent office staffing remains an issue.

Evidence Base Care/Effectiveness

The well-supported international recommendations for cooling of patients after cardiac arrest cannot be implemented in DCC due to lack of equipment.

The latest ICNARC report shows that we have the highest rate of night discharges in our comparator group. It is known that patients discharged "out of hours" have higher mobidity and mortality rates, and a higher incidence of readmission to critical care.

The infrastructure changes for the dialysis programme are now complete. Staff education is being organised.

The guidelines group has introduced or modified several guidelines (enteral feeding, glycaemic control, sedation, CVP line management, bowel management, prone positioning).

Education
Combined teaching sessions continue to be useful and successful. Such sessions are now organised with Cardiology, Renal and the Emergency Department. A combined mortality review with the Colo-rectal surgeons was organised in May. A number of important issues were identified and will be followed up.